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AUTHOR McKee, John M.
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ABSTRACT

The case for behavior modification and some examples of its application in a variety of correctional settings are presented. The principles, techniques, and strategies utilized in programs designed to induce behavior change are largely determined by the model of causality to which one subscribes. A new approach to human behavior, which is the result of a rapproachement between psychology as a basic and an applied science, represents the first attempt to develop a viable science of human behavior which allows the practitioner to implement experimentally derived and validated principles in an applied setting. The hallmarks of this approach are empiricism and objectivity. Deviant behavior is depicted as acquired in the same manner as normal behavior, and consequently, as amenable to modification through the appropriate use of the laws of learning. Diagnosis is the tool used by more and more professionals to discover the reason for behavioral deviancy. The four functions of diagnosis are: (1) It specifies in what manner an individual differs from those around him; (2) It identifies the causes or origins of the individual's deviance; (3) It supplies information as to what will transpire if no remedial action is undertaken; and (4) It specifies what intervention strategy will be most effective dealing with the deviancy. The guidelines given for use of diagnosis include: (1) a clarification of the problem situation, (2) a motivational analysis, and (3) an analysis of self-control. (CK)

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THE APPLICATION OF BEHAVIOR THEORY TO CORRECTIONAL PRACTICE*

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John M. McKee, Ph.D.
Rehabilitation Research Foundation
Elmore, Alabama 36025

The aim of this presentation is to set forth, in a brief manner, the case for behavior modification and some examples of its application in a variety of correctional settings. This paper will be followed by a tape-slide presentation of current work of the Experimental Manpower Laboratory for Corrections (EMLC) at Draper Correctional Center, Elmore, Alabama. The pervasive orientation of this Laboratory is the experimental analysis of behavior, which has been ongoing during the past ten years in a wide range of institutional and community corrections problems.

The Shortcomings of the Medical Model

The principles, techniques, and strategies utilized in programs designed to induce behavior change are largely determined by the model of causality to which one subscribes. Traditional psychological thought, and the thought of those in related fields who would employ a psychological approach in the remediation of the particular problems with which they are faced, stresses a "disease," or "medical model," explanation of deviant behavior. Within this context and at the risk of oversimplification, an individual's presenting problems are taken as symptomatic of some underlying psychic imbalance (commonly referred to in general terms as a disturbed or disorganized personality), and the role of the professional is to focus upon that imbalance, treat the existing disturbance or disorganization, and, eventually, effect a cure. A successful cure is hypothesized to result in permanent remission of the presenting problems or symptoms, and the individual will then be able to find a productive, self-fulfilling niche in society.

Embodied in this approach to deviancy are a multitude of highly abstract concepts, such as "unconscious dynamics," "complexes," "repression," "transference relationship," "gaining insight," "interpreting the defenses," "personality," "coming face-to-face with reality," etc. Because these concepts appear reasonable and are integrated into formalized and logical theories, they assume an aura of face validity. In addition, through their constant

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and unquestioned repetition and elaboration among professionals, they have now attained "truth" status. Unfortunately, this approach to the understanding of human behavior has two major shortcomings: first, the concepts composing the theories are stated in vague and ambiguous terms, thereby prohibiting their effective communication to students and line workers and, in effect, reserving this approach as the special domain of the highly skilled, highly trained professional. Second, and more importantly, the theories themselves are, by the very nature of their ambiguously defined constructs and formalized internal consistency, constructed in such a manner as to render them all but impervious to disconfirmation. This, in turn, makes it impossible to test and either prove or disprove the products and validity of this form of theorizing.

In the past decade there has occurred in applied psychological thought a veritable revolution in the manner in which human behavior is examined, understood, and dealt with. This new approach is the result of a rapprochement between psychology as a basic and as an applied science. It represents the first attempt to develop a viable science of human behavior which allows the practitioner to implement experimentally derived and validated principles in an applied setting. These principles are stated in clear and unambiguous terms, thereby permitting their easy communication to students and line workers and providing them the tools they so desperately need to become effective change agents. The theory from which these principles arise eschews the use of internal entities or processes inferred from the behavior they pretend to explain and deals instead with specifiable relationships between acts and their consequences as a medium through which the causes of behavior may be understood. Consequently, its validity is open to evaluation.

Unlike the more traditional approach, the hallmarks of this new approach are empiricism and objectivity. The new practitioner recognizes the importance of constantly monitoring and evaluating his progress in an empirical manner, and the statement of goals and desired outcomes in objective terms allows him to do so. Only by so doing can the effectiveness of the procedures which have been implemented be determined and, if found lacking, be replaced by alternative procedures. The adherents to this approach, variously labeled "operant conditioning," "behavior modification," "contingency management," or "behavior therapy," see behavior as lawful, that is, as a natural result of the past learning history of the individual, the social context within which the individual acts, and the regular consequences of his behavior.

Deviant behavior is depicted as acquired in the same manner as normal behavior and, consequently, as amenable to modification through the appropriate use of the laws of

learning. More specifically, by conceptualizing antisocial behavior as behavior which is acquired, maintained, and modified in accord with the same principles as are other behaviors, it is possible to develop programs which discourage, weaken, and eliminate target deviant behaviors while at the same time instilling, strengthening, and maintaining constructive, prosocial behaviors in their place. A primary goal of the behavioral approach to deviancy, then, is to determine the functional relationship between target behaviors and environmental events which maintain them and/or have the potential of modifying or eliminating them. Comparisons between the behavioral and the more traditional approaches to deviancy indicate that the behavioral approach is more effective, either in terms of the amount of change observed, the amount of time required to produce change, or both.

The Case for Diagnosis

More and more professionals in corrections are talking "diagnosis," a concept borrowed in large part, if not completely, from the psychiatric profession. The psychiatric profession has, in turn, adopted this procedure from their fellow professionals who are dealing with medical--i.e., physical or organic--problems. And, of course, diagnosis in terms of medical problems has proved a fruitful aspect of medical treatment. The question I am raising is whether or not this "medical modeling" is a productive endeavor of the psychiatric profession, and whether or not it is one to which correctional personnel should devote a large part--or any part--of their time. It appears, at first glance, that diagnosis is the logical way to go in corrections, as it does in psychiatry. The logic behind diagnosis--be it psychiatric or correctional--is compelling. Marguerite Q. Warren, discussing the differences between offenders, has noted that "...they (offenders) differ from each other not only in the form of their offense, but also in the reasons for and the meaning of their crime. Some individuals violate the law because the peer group, upon which they depend for approval, prescribes criminal behavior as the price of acceptance, or because the values, which they have internalized, are those of a deviant subculture. Other individuals break laws because of insufficient socialization, which leaves them at the mercy of all but the most protected environments. Still others delinquently act out internal conflicts, identity struggles, or family crises. The list is of course illustrative, not exhaustive (Warren, 1971, p. 239)." This list, I might add, is not only not exhaustive, but endless. Diagnosis is the tool we use to make sense out of all this.

Let us look at diagnosis realistically. Diagnosis exists because it is assumed to fulfill at least four functions for the practitioner. First, the diagnosis specifies in what manner an individual differs from those around him. Secondly, the diagnosis typically identifies the cause or origins of the individual's deviancy–its etiology. Thirdly, it also supplies information as to what will transpire if no remedial action is undertaken–the prognosis. And finally, it specifies what intervention strategy or strategies will be most effective dealing with the deviancy–i.e., the diagnosis specifies treatments of choice. It must be noted that once an individual is diagnosed, the diagnosis cannot do less than bias the practitioner, for it specifies how the labeled individual should behave; what to look for in his past to explain his deviancy; what to expect of the people if he remains untreated; and what to do with and what to expect of the individual in treatment. There is ample evidence to indicate that individuals conform to our expectations, especially in the therapeutic setting. It is safe to say that when we treat diagnostic categories, the diagnosed individual potentially remains untreated, or worse.

Does diagnosis "work"? Does it do more than instill in the practitioner a number of self-fulfilling prophecies? It is premature to make a decision in terms of correctional diagnosis, but if we look at the research done concerning psychiatric diagnosis we will be able to put diagnosis in its proper perspective and to point out what we must concern ourselves with before we become advocates of diagnosis per se. First let us look at the degree to which diagnosticians agree upon what diagnostic label should be affixed to what individual. Both Schmidt and Fonda (1956) and Beck, Ward, Mendelson, Mock, and Erbaugh (1962) report similar findings concerning the agreement of diagnosticians. Agreement is high with respect to the gross diagnostic categories (i.e., functional versus organic), but it drops radically as more and more discriminating diagnoses are required. To the degree that fine discriminations are required in diagnosis–at least in psychiatric diagnosis--the system produces more disagreement than agreement among skilled diagnosticians as to what an individual "really" is. Who is correct and who is incorrect, and what, if any, external criterion may we employ to determine the reliability of these diagnostic practices? I, for one, am ready to admit that I don't know.

It is logical to expect that persons placed in the same diagnostic categories should be more like each other than they are like those placed in alternative diagnostic categories. However, a number of studies have indicated that this may not be the case (Wittenborn, Holzberg, and Simon, 1953; Lorr, Klett and McNair, 1963). These studies reveal that the behavior of individuals given the same diagnostic label is far from uniform. Instead we

see clusters of behavior within the same categories, and quite often these clusters are mutually exclusive--that is, it is impossible for some members of a given category to manifest the behavior of others in that same category by the very nature of the behavior they do manifest. On the other side of the coin, there are clusters of behavior shown by members of one diagnostic group which are seen to an equal degree by members of other diagnostic groups. In general, then, people assigned to one diagnostic category are frequently as *unlike* others in that category as they are *like* members of other categories. If these categories are indistinguishable on the basis of how the people assigned act, on what basis are they distinguishable?

The third and most important aspect of diagnosis is that it dictates treatments of choice. If this is indeed the case we would expect the treatments of choice dictated for each diagnostic category to be closely followed, for by so doing the practitioner would maximize the probability of success with regard to each treatment group. In this regard, Bannister, Salmon, Leiberman (1964) have examined the degree to which members of these categories do, in fact, receive the prescribed treatment of choice. They report that the relationship between diagnostic category and treatment is so low as to be almost unimportant. This is probably the most encouraging of these three findings, for it is implicit verification by the psychiatric profession that their diagnostic procedures do not work.

If diagnosticians cannot agree concerning diagnosis, and if people assigned to the various diagnostic categories are undifferentiable along any meaningful dimensions, why should we expect the treatments of choice associated with each category to be any more, or less, effective than alternative treatment procedures? What, then, is the value of psychiatric diagnosis? I, again, admit that I don't know. In fact, I fail to see why the psychiatric profession, in the face of this kind of evidence, continues to cling to the belief that diagnosis is an important part of their role. Perhaps, as I indicated before, it is because diagnosis, in the context of the medical model of psychiatric disorders, *appears* a logical way to go, and for this reason alone psychiatric diagnosis continues to be with us.

These are the kinds of problems we should consider when we contemplate the role of diagnosis in corrections. Not enough research has yet been conducted to completely determine the value of diagnosis for us. Before we become caught in the classification trap, we should at least profit some from what has transpired in the mental health field. Let us look first at the reliability of correctional diagnosis; then at the similarities and differences between those actually diagnosed, not at those similarities and differences we see depicted in the idealized testbook cases; and, finally, and again most importantly,

let us determine the value of the forms of intervention prescribed for each diagnostic category. Are these forms of treatment more effective than the forms of treatment prescribed for other categories, and, of equal importance, are they better than no treatment at all? I am not arguing against diagnosis per se; I am arguing against the premature avocation of diagnosis, and, perhaps, I am also arguing against correctional diagnosis following the same path as psychiatric diagnosis. This path, which leads into the offender--into him in the sense that we construct all sorts of "personality types," "needs," "traits," and "internal dynamics" to explain in a circular manner the activities from which they are inferred--has proven, I believe, to be all but useless in other fields. I have no reason to believe that this form of diagnosis will be any more successful in the correctional field.

Should we eschew all forms of diagnosis? Of course not. The goals of diagnosis are indeed sound. It is, as I have indicated, the form of diagnosis we appear to be adopting I believe to be unsound. What the enlightened members of the mental health field are now advocating, i.e., "behavioral diagnosis," is what I would advocate for corrections as well. If I may borrow from Frederick Kanfer and George Saslow (1969), I would suggest that behavioral diagnosis in corrections should proceed according to the following guidelines:

1. A detailed description of the particular behavioral excesses or deficits which are, in actual fact, the manifestations of the offender's deviancy; and a detailed description of the offender's manifest, behavioral assets, which will provide the basis for a rehabilitation program.

2. A clarification of the problem situation, that is, a search for the environmental variables which contribute to or maintain the offender's deviant behavior(s).

3. A motivational analysis to determine the various incentive and avoidance conditions which represent the dominant motivational factors for the offender.

4. An analysis of self-control which provides assessment of the offender's capability for participation in a rehabilitation program, the conditions which may be necessary to institute control, and what may be done to develop self-control.

5. An analysis of social relationships in the offender's environment which pinpoints resources which will benefit and deficits which will impede his postrelease success. Both aspects must be dealt with, by the institutional rehabilitation program during an offender's incarceration and by the appropriate agencies following his release.

6. An analysis of the offender and the environment to which he will return, so that the rehabilitative goals we decide upon are realistically feasible, not only in terms of what may be accomplished, but also in terms of the congruence between what we have accomplished and the offender's role in society.

Each of these six categories deals first with the behavior of individuals, and then leads to programs for individuals. Perhaps it is possible to classify offenders in terms of these guidelines--I don't know at this point, and, if the truth be known, it does not concern me much. When we classify we do make our day-to-day jobs a bit easier, but we do a disservice to those with whom we work. When we work with individuals as individuals we do indeed work a bit harder, and I believe we do a better job. And that is what I believe we all want to do--a better job. For those looking for an easy job, they had best look elsewhere.

Applications of Behavior Modification to Correctional Settings and Problems

It appeared important to me to approach the topic of this presentation–the application of behavior theory to corrections–by first dealing with a practice. Now, I would like to describe some applications of the behavioral approach. Though less frequently practiced, the principles and procedures of behavior modification are becoming increasingly evident in both institutional and community programs. Moreover, reports of the successful application of behavior modification techniques are becoming increasingly evident in professional literature.

The earliest studies (Cohen et al., 1967; Clements and McKee, 1968) sought to establish motivational contingencies for educational achievement in institutional settings. Then followed the current trend of programming entire living and working environments for adolescent and adult offenders (Burchard, 1967; Cohen et al., 1968; Tyler and Brown, 1968; Wolf, 1971; Phillips, 1968; Milan, 1971; Milan and McKee, 1971; DeRisi, 1971). And here in Hawaii I was interested to learn about a token reinforcement project (1970) in operation at the Hawaii Youth Correctional Facility. I am sure that since the report on this program was written improvements in the token economy system have already taken place. Behavior modification efforts can also be witnessed in community settings, as noted by Patterson's (1971) work with parents of delinquents and schools, and James' (1971) project with juvenile courts and probation personnel.

At this point, I shall show a slide presentation of the work of the Experimental Manpower Laboratory for Corrections at Draper Correctional Center, Elmore, Alabama. Most of the studies being conducted in this Laboratory are based on the behavioral model.

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